Quality, Affordability and Transparency: A New Era for Medi-Cal?

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Overview

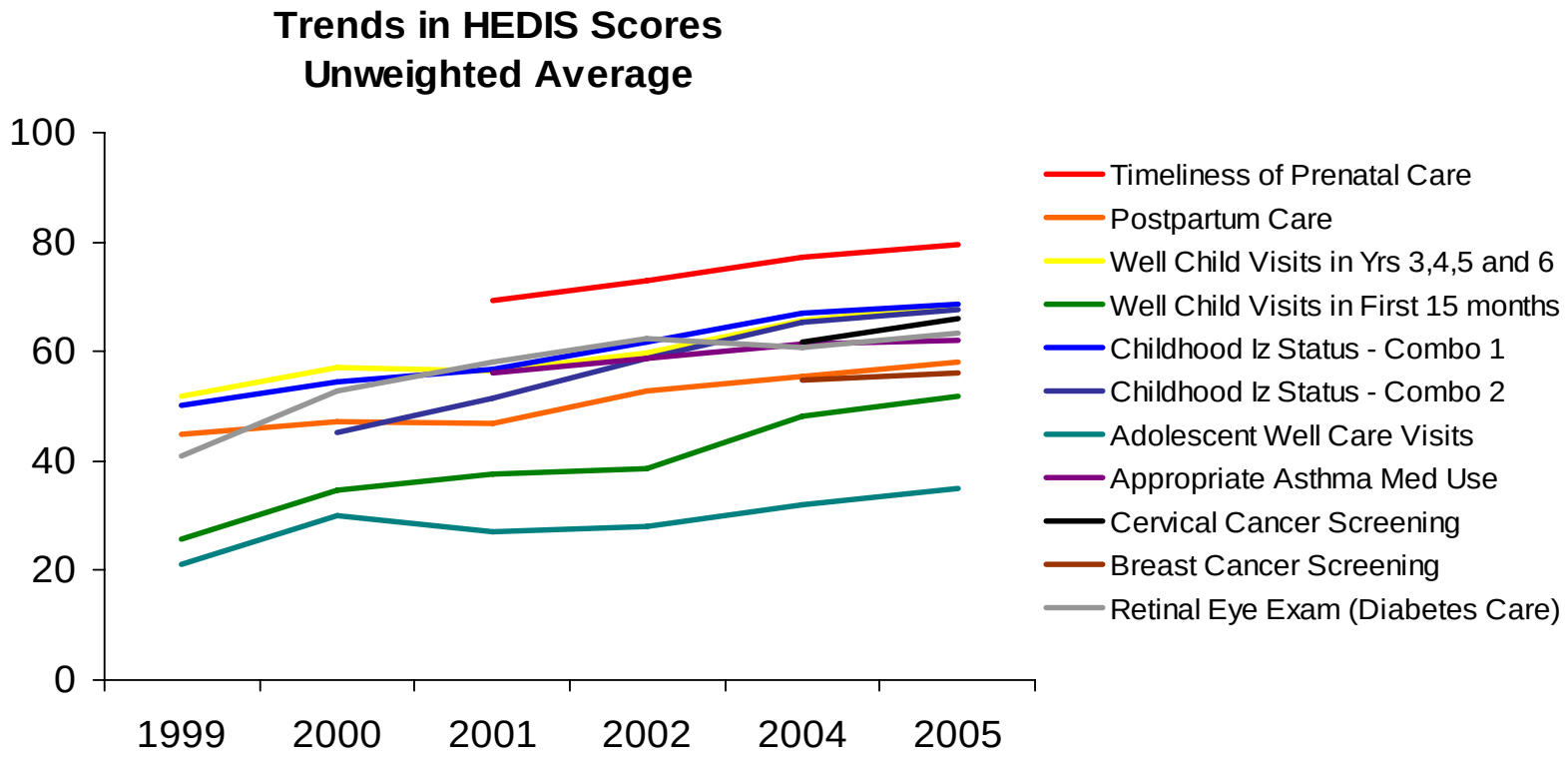
- Medi-Cal Managed Care in Review
- Implications of Health Reform
- What You Can Do: The Value Agenda
- Discussion/Questions

Has Medi-Cal managed care been a success?

- Has it improved the **quality** of care provided to Medi-Cal members?
- How it improved **access** to care for Medi-Cal members?
- Has it helped state to control Medi-Cal **costs**?

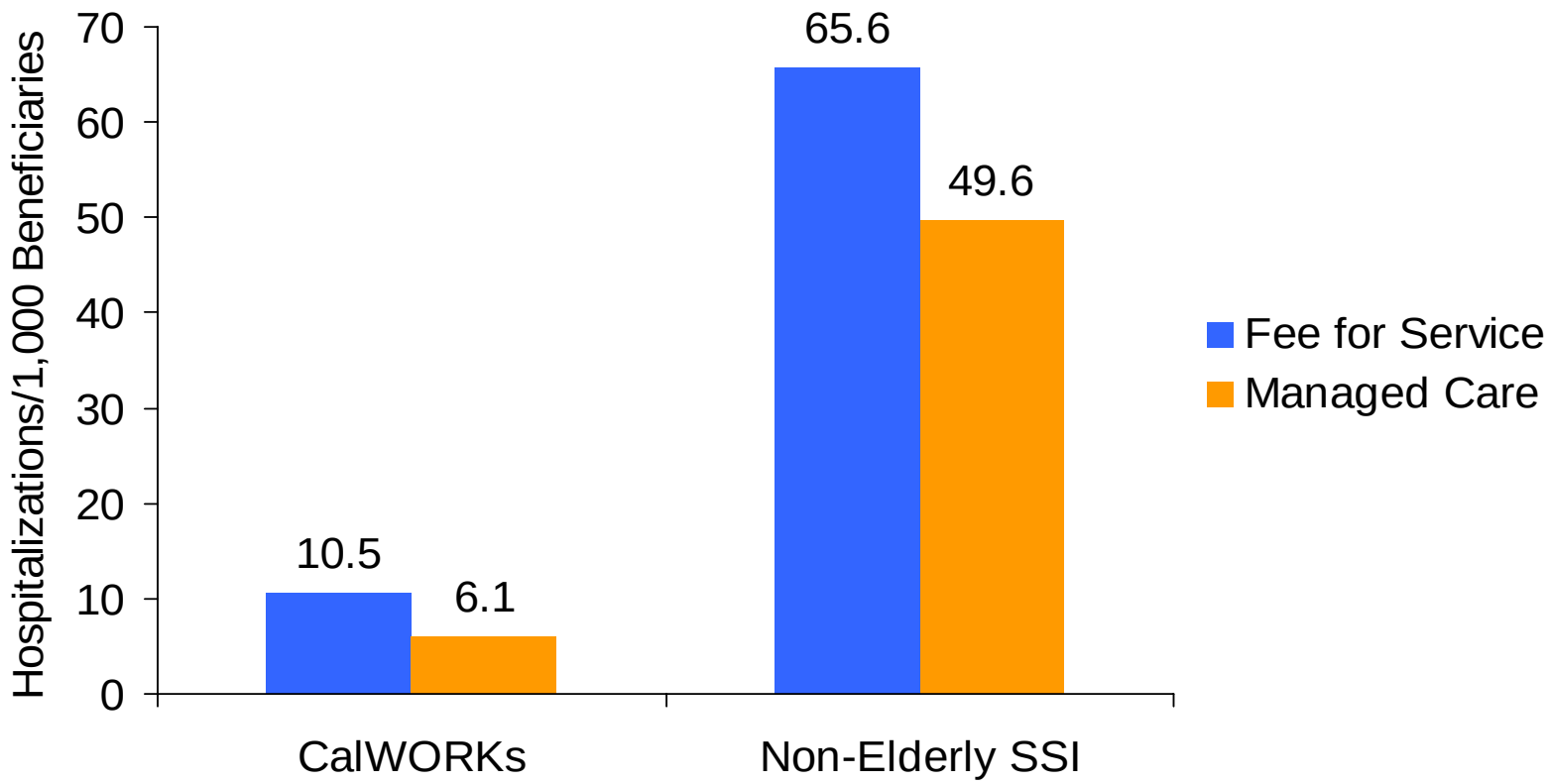
The good news on Quality

There has been a steady increase in HEDIS scores



The good news on Access

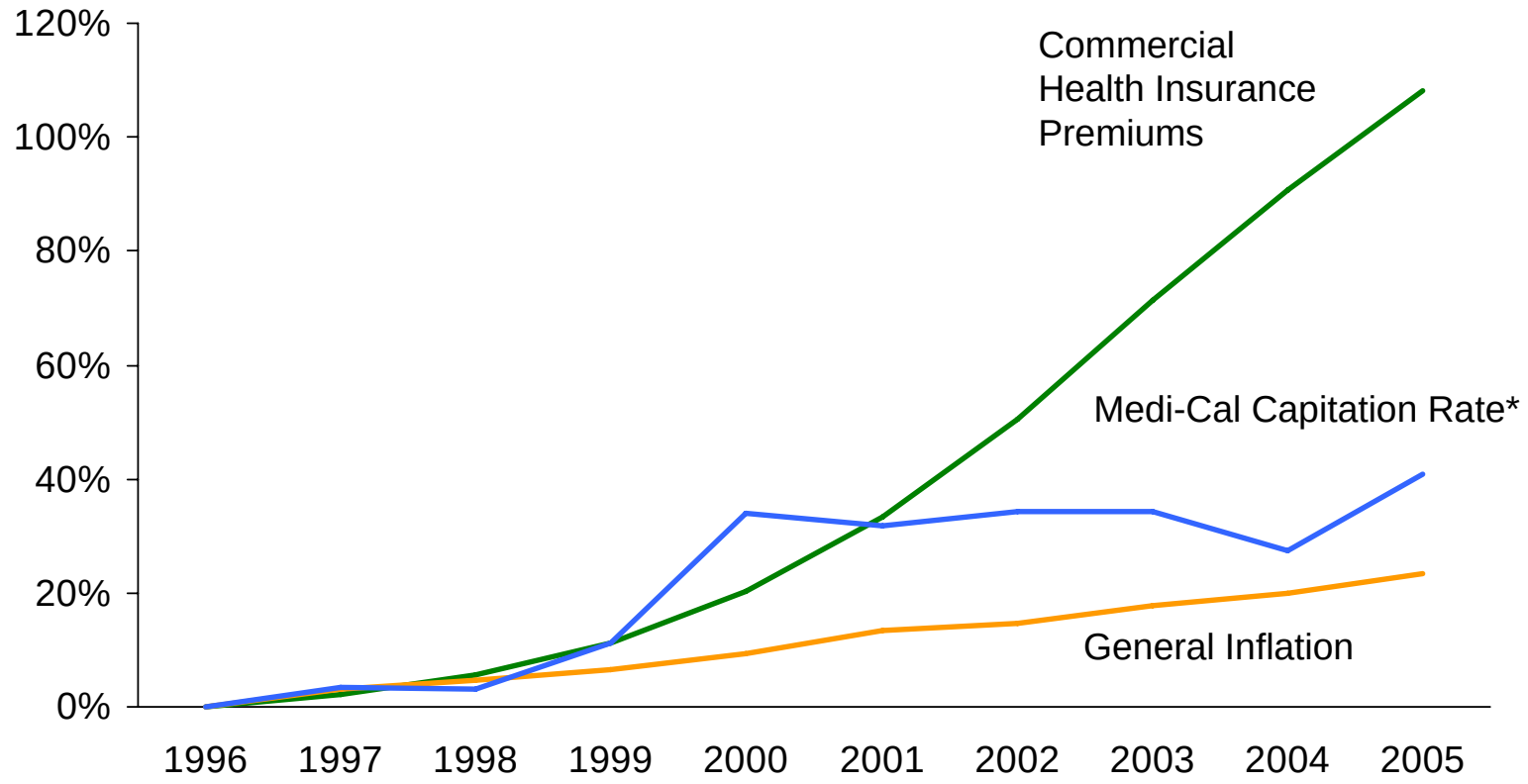
Preventable hospitalization rates are lower in Medi-Cal managed care than in FFS



Note: Average annual rates of hospitalizations for ambulatory sensitive conditions, 1994-2002, adjusted for beneficiary demographics, county of residence, and month of admission
Source: A. Bindman, et al., UCSF (draft report to CHCF)

The good news on Costs

The growth of Medi-Cal capitation rates has been substantially less than commercial premiums

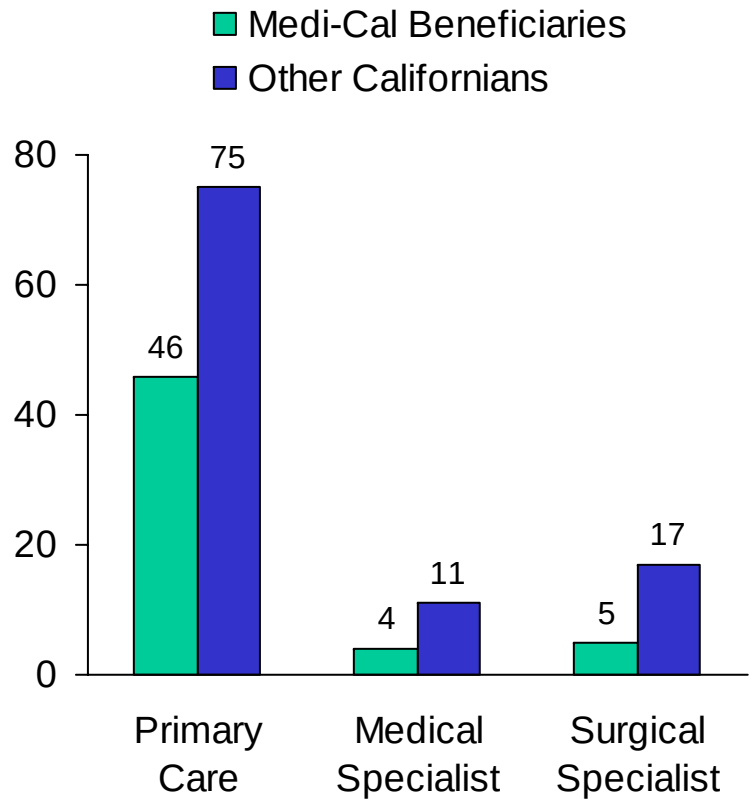


Note: Medi-Cal trend reflects capitation rates for LA Care for the AFDC/Family rate. Similar growth rates were observed for the Alameda Alliance for Health. Growth rates varied by plan and by rate category.

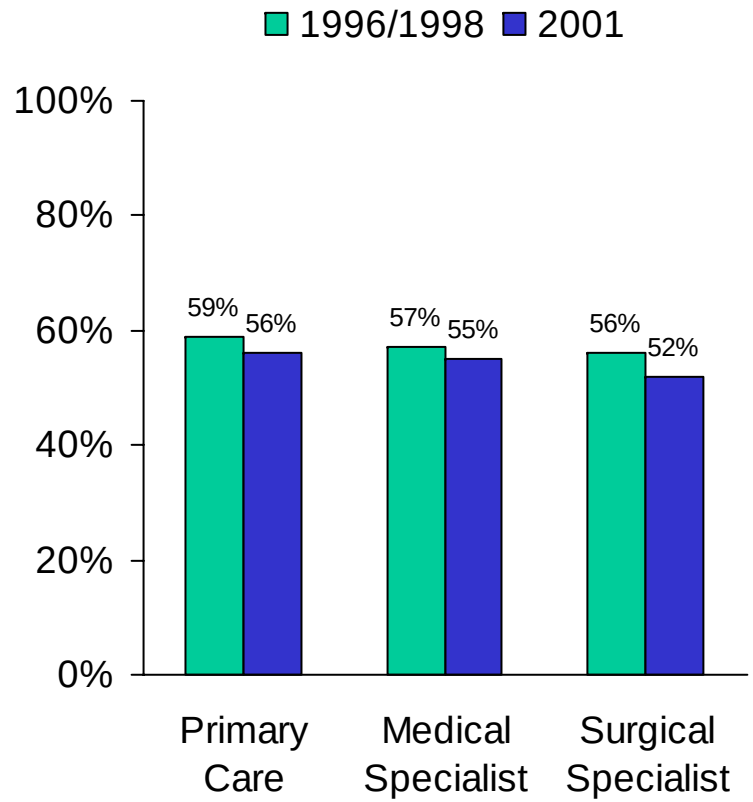
The bad news on Access

Physician participation in Medi-Cal is low, and managed care appears to have had no measurable impact

Physician Participation in 2001, FTEs/100,000



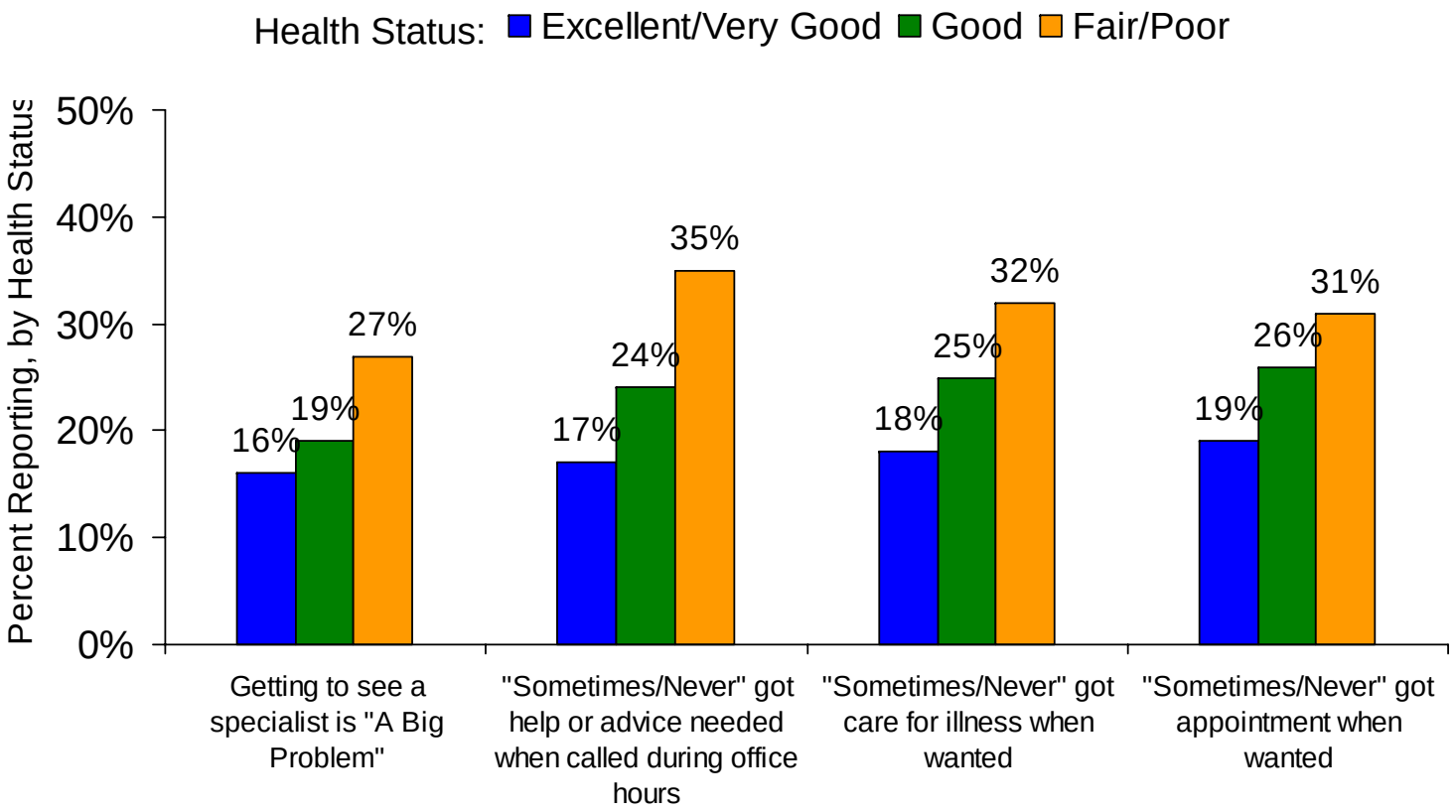
Percent of Providers Participating in Medi-Cal



Source: Adapted from A. Bindman et al, Physician Participation in Medi-Cal, 2001 (CHCF)

More bad news on Access

Many members – especially those who need services the most – experience difficulty getting need care



Notes: Unweighted percentages based on average of scores of five largest plans, accounting for over one-half of Medi-Cal managed care enrollment (LA Care, Blue Cross-CP/non-GMC, CalOptima, HealthNet-CP/non-GMC, and IEHP). For specialist care, response options were “Not a problem,” A small problem,” or A big problem.” For all other questions shown, response options were “Always”, “Usually,” Sometimes,” or “Never.”

The bad news on Costs

Debate continues as to whether managed care saves Med-Cal money

"We estimate the state is probably saving in the hundreds of millions of dollars annually on patient care because of the shift of beneficiaries into managed care."

- LAO

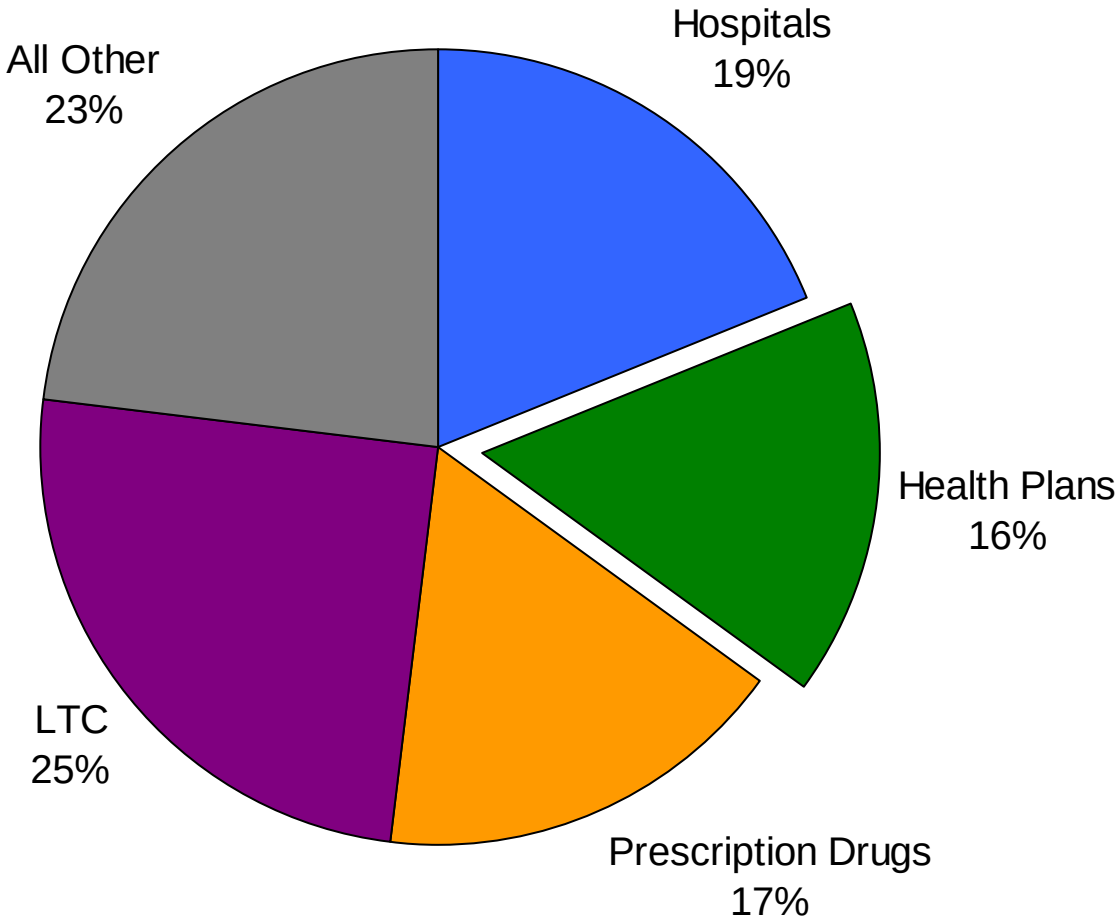
"Managed care contracting reduced the efficiency of the Medicaid program in California. In fact, Medicaid spending appeared to increase by almost 20 percent following the shift to managed care."

- Mark Duggan, University of Maryland

Sources: LAO, "The 2004-05 Budget: Perspectives and Issues" (February 2004) and Academy Health, "Managed Care Mandates Fall Short of Curbing California Medicaid Costs" (March 2005).
Notes: Duggan study based on Medicaid spending from 1993-1999.

The Opportunity is There

Health plans “manage” fewer than 1 in 6 Medi-Cal dollars



Source: CHCF Medi-Cal Budget and Cost Drivers, January 2006. Based on Medstat analysis of Medi-Cal MIS/DSS data updated through September 2005. Reflects $28 billion of $34 billion in Medi-Cal spending (excludes DSH and other supplemental hospital payments, administrative expenses and certain other costs)

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Implications of Health Reform in California

Health Reform in California

- Leading Proposals:
  - Governor Schwarzenegger
  - Senate President Pro Tem Perata
  - Assembly Speaker Núñez
  - Senator Kuehl
  - Senate Republicans
- What are the implications for Medi-Cal plans?
  - Opportunities
  - Challenges

Opportunities Under Health Reform

- Expansion of existing public programs is a component of three of five proposals, as source of both coverage and financing
  - Schwarzenegger: Medi-Cal expansion for all legal residents up to 100% FPL. Healthy Families expansion for children up to 300% FPL, regardless of immigration status.
  - Perata: Medi-Cal expanded for working parents up to 300% FPL. Healthy Families expanded for children up to 300% FPL, regardless of immigration status.
  - Nunez: Expands coverage for all children up to 300% FPL through expansion of Medi-Cal and Healthy Families. Would extend coverage to low-income adults within 5 years.
  - *Kuehl: Replaces private health insurance and existing public programs with a single government-administered system*
  - Senate Republicans: no major expansion
- Governor's proposal would increase Medi-Cal payment rates to "near Medicare" levels, which might increase capitation rates to participating health plans

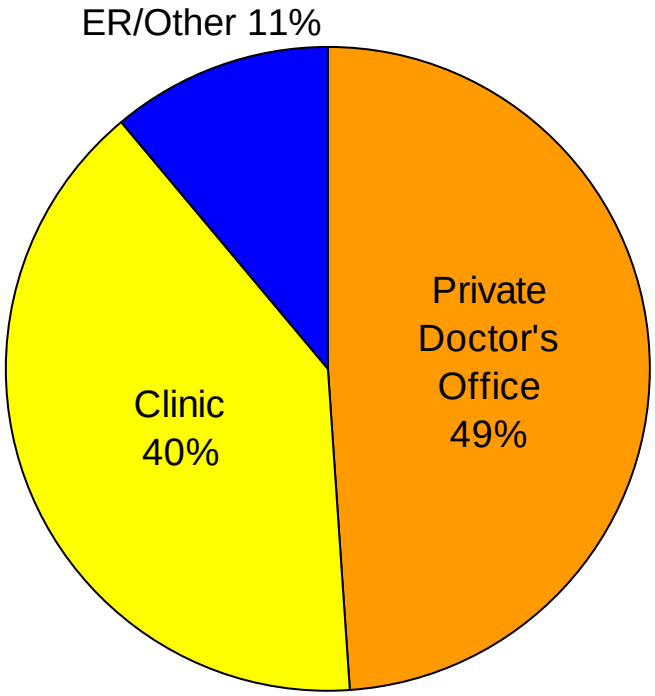
Challenges Under Health Reform

- New competition from commercial plans?
  - Under Perata and Schwarzenegger proposal, many low-income individuals – including some currently covered by Medi-Cal – would get coverage through Connector/Purchasing Pool
  - How will Medi-Cal plan networks – which rely heavily on traditional safety net providers - be viewed by **customers** who have other options?
- With higher FFS payment rates, providers and beneficiaries who have a choice may no longer find managed care more attractive than FFS

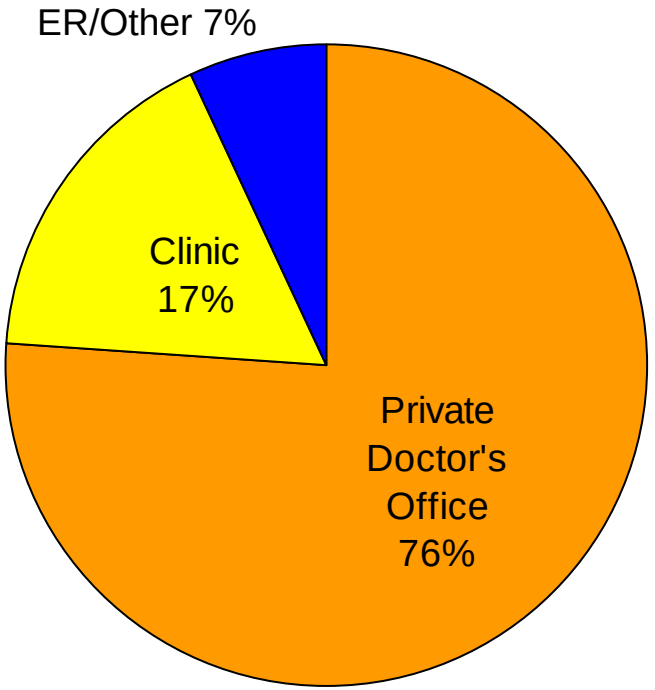
What More Options Might Mean

Given the option to get their care in a private doctor's office, few beneficiaries would choose to get their care in a clinic or ER

Usual Source of Care



Preferred Source of Care



Source: CHCF/MCPI, "Speaking Out…What Beneficiaries Say About the Medi-Cal Program" (March 2000)

Is Reform Possible?

- 2007 represents a significant opportunity
- Significant coverage expansion *is* possible – "universal" may not be
- Cost control is an immediate and long-term requirement for expanded coverage
- Quality improvement is an imperative
- All changes will create winners and losers

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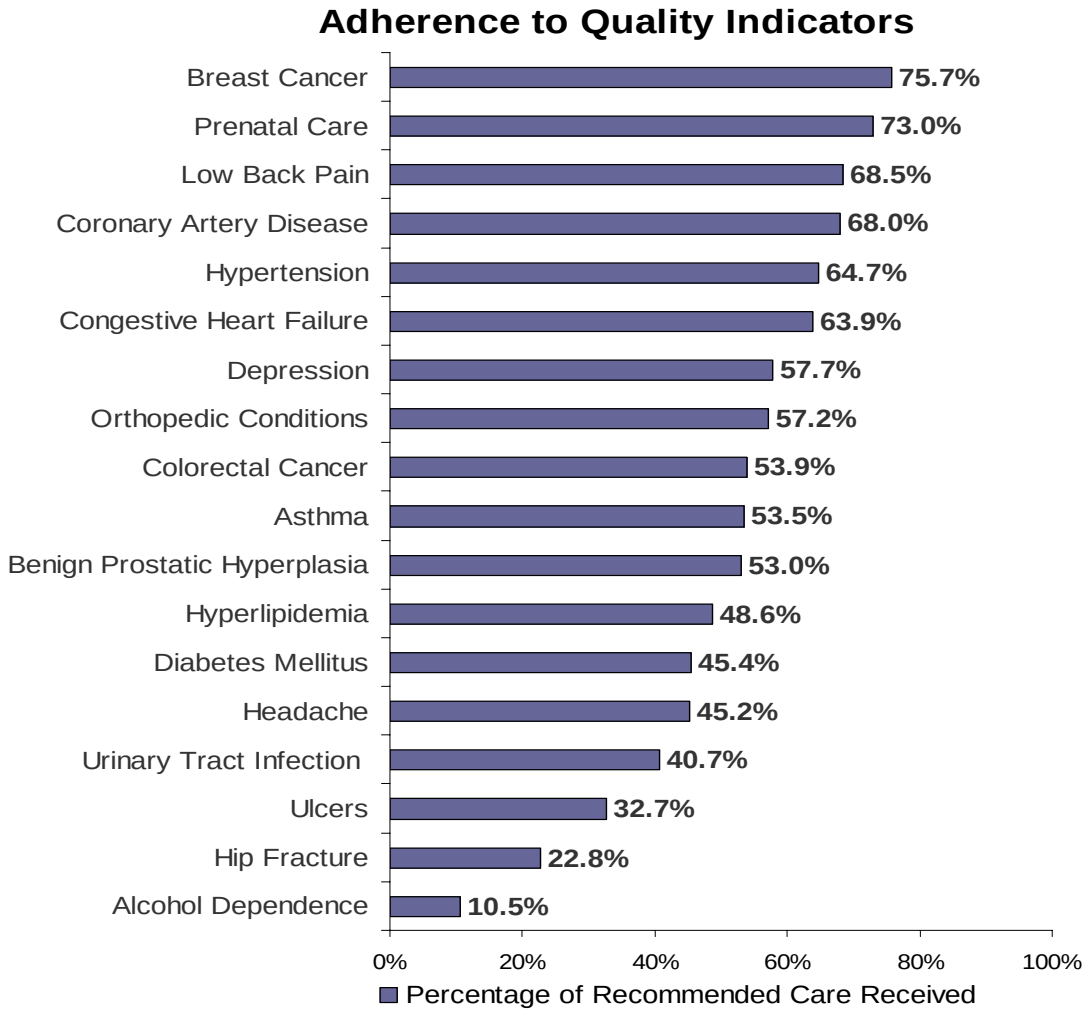
What You Can Do: The Value Agenda

Quality Shortfalls: Getting it Right 50% of the Time

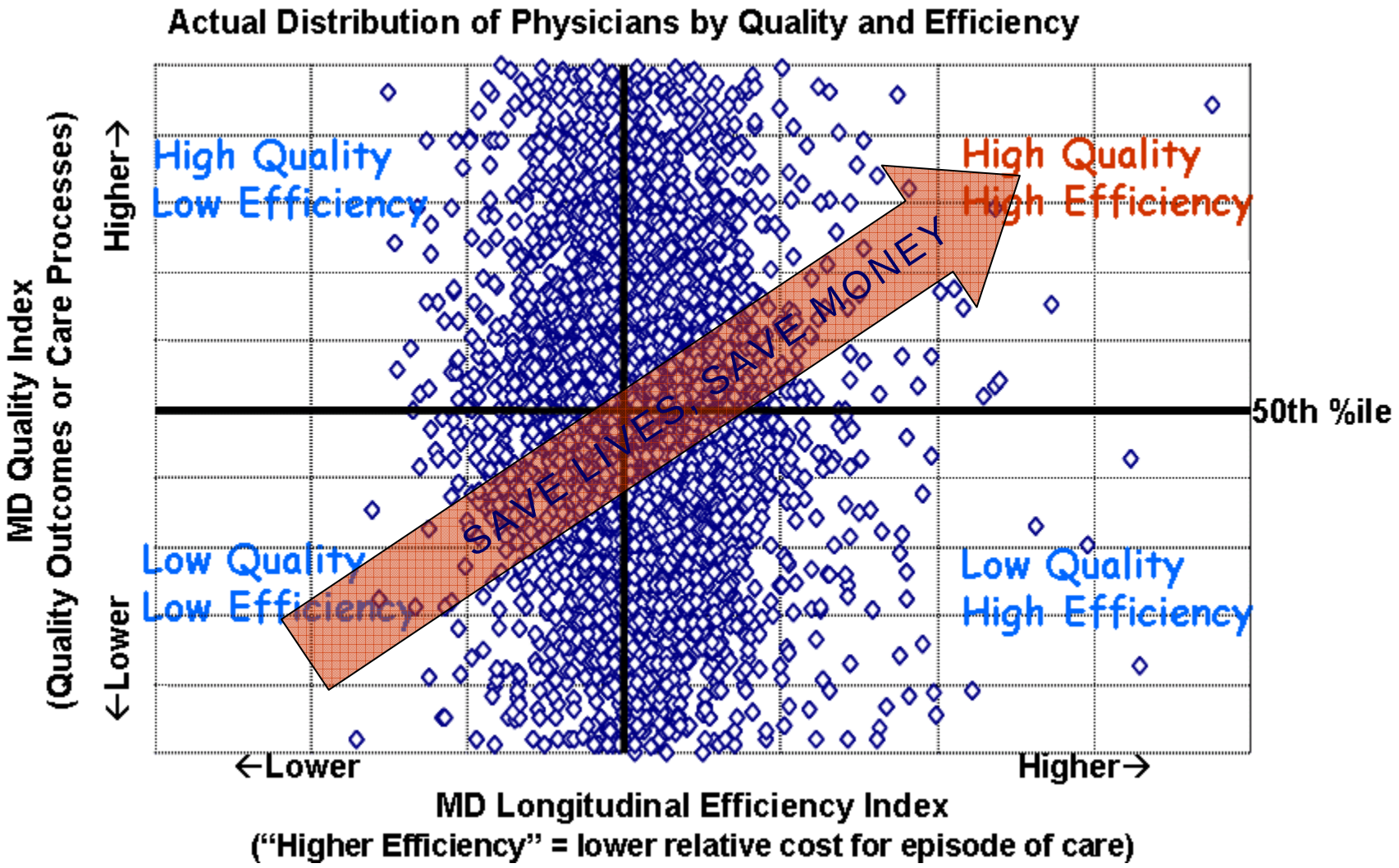


Adults receive about half of recommended care

- ***54.9% = Overall care***
- ***54.9% = Preventive care***
- ***53.5% = Acute care***
- ***56.1% = Chronic care***

Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, Vol. 348, No. 26, June 26, 2003, pp. 2635-2645

Inconsistent Provider Quality and Efficiency



Adapted from Regence Blue Shield

The Value Agenda: What You Can Do

- Prevention and Health Promotion
  - Model incentive programs for prevention
  - Obesity prevention; wellness programs
  - Implement chronic disease programs (start with diabetes)
  - Lead the way in developing new models of care management to serve beneficiaries with multiple chronic conditions
  - Expand the reach of self-care

- Transparency and Quality Information
  - Expand reporting on health care outcomes and costs, particularly for seniors and people with disabilities
  - Support the development of new measures and reporting for carved-in (e.g., hospitals) and carved-out (e.g., mental health, LTC) services, as well as care coordination across providers
  - Partner with private sector efforts to aggregate data for quality improvement, payment and consumer choice

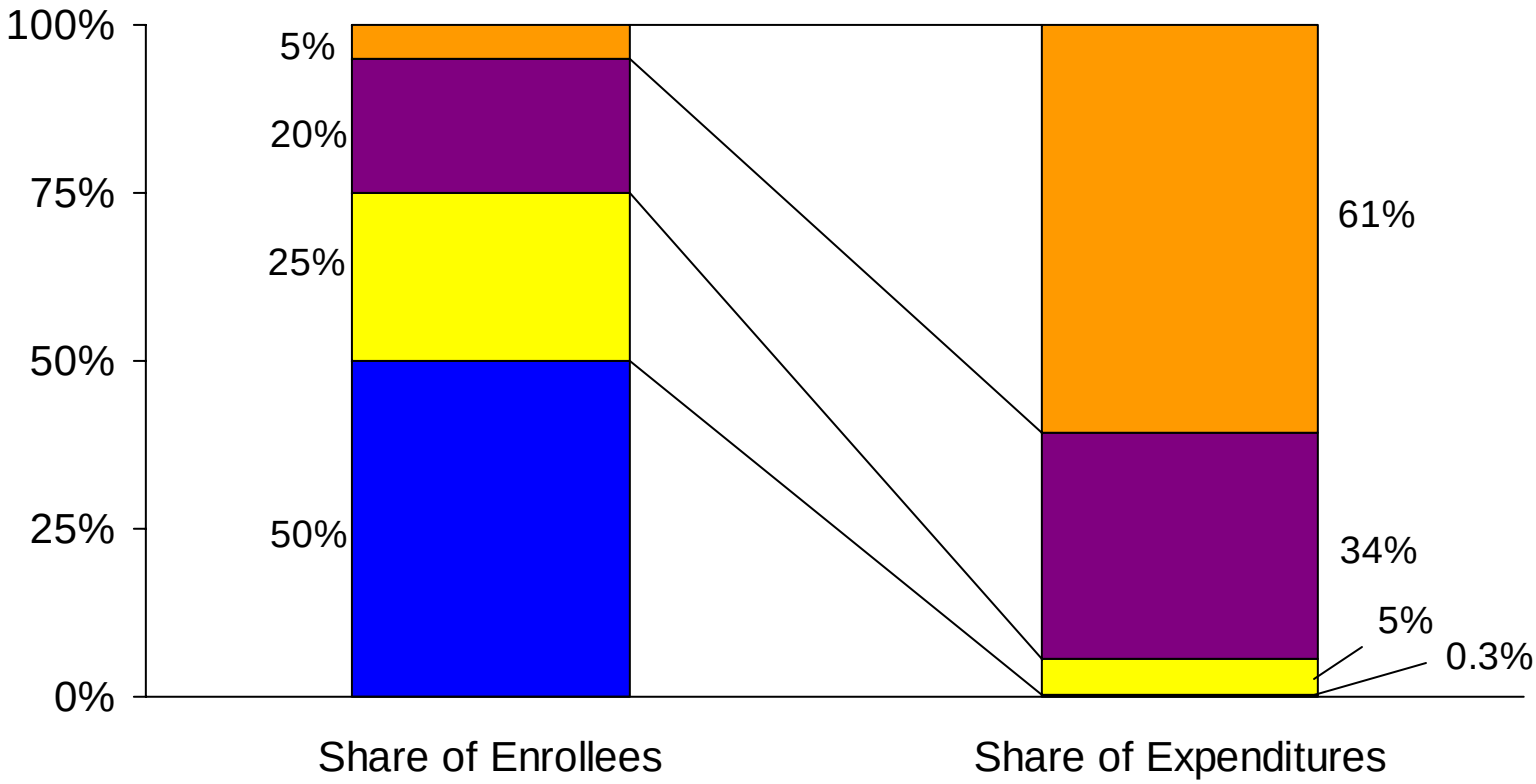
The Value Agenda: What You Can Do

- Delivery System/Reengineering
  - Link payments to performance improvement
  - Promote health IT
  - Require e-prescribing (reduce medical errors)
  - Technology assessment process for evidence-based care
  - Promote more convenient and affordable care by allowing more flexibility in training and use of various health providers
  - Limit amount hospitals can charge for “out-of-network” care
  - Foster collaboration and integration across systems

Partner/ collaborate with other payers to align incentives and amplify impact, and provide assistance to high-volume, low-performing providers to foster change

In Medi-Cal, Value Agenda Should Focus on High-Cost Beneficiaries

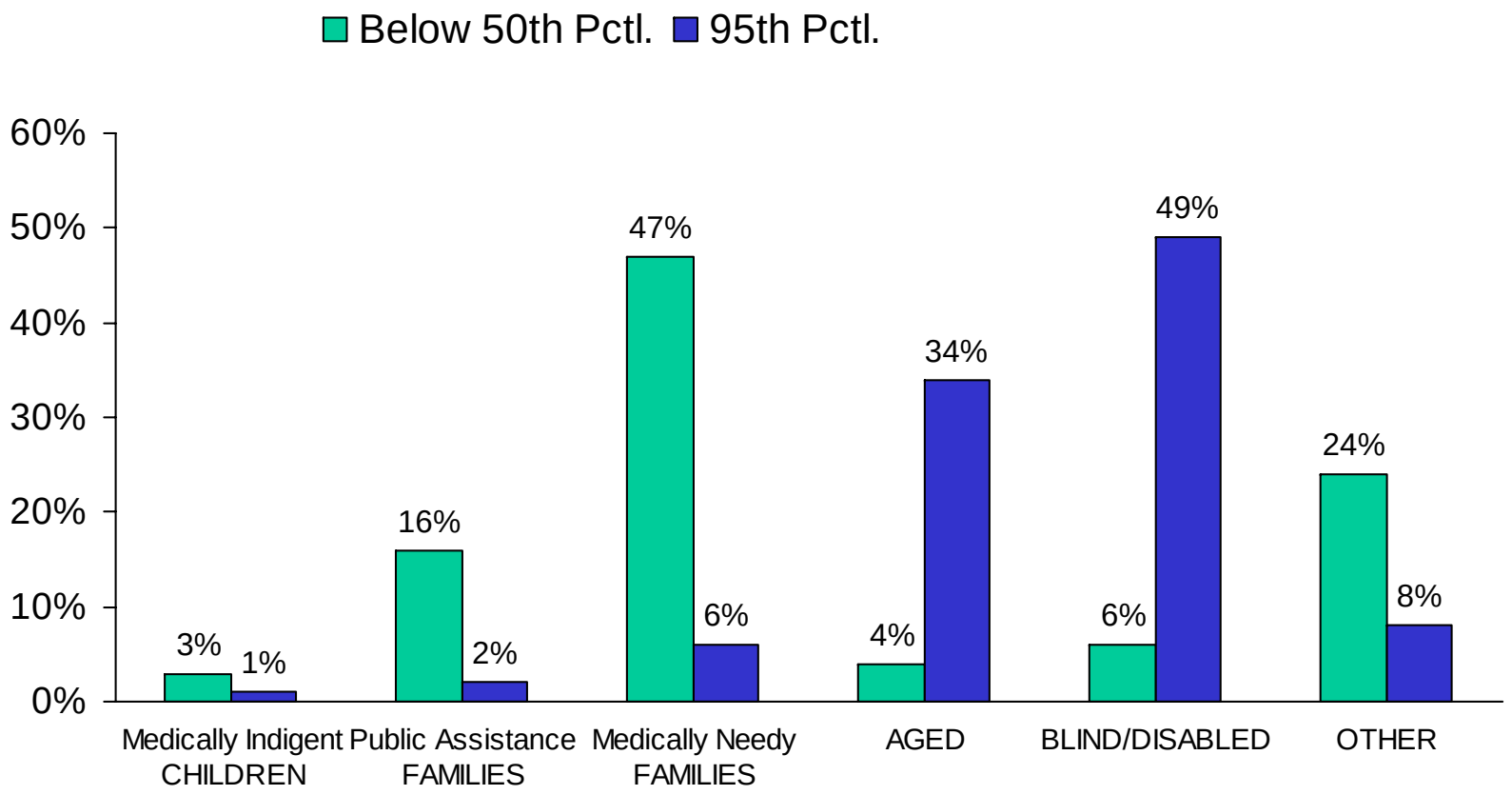
Spending is even more concentrated than in the private sector



Source: Public Policy Institute of California, Medi-Cal Expenditures: Historical Growth and Long-Term Forecasts (June 2005)

Most High-Cost Medi-Cal Beneficiaries Are Seniors and People with Disabilities (SPDs)

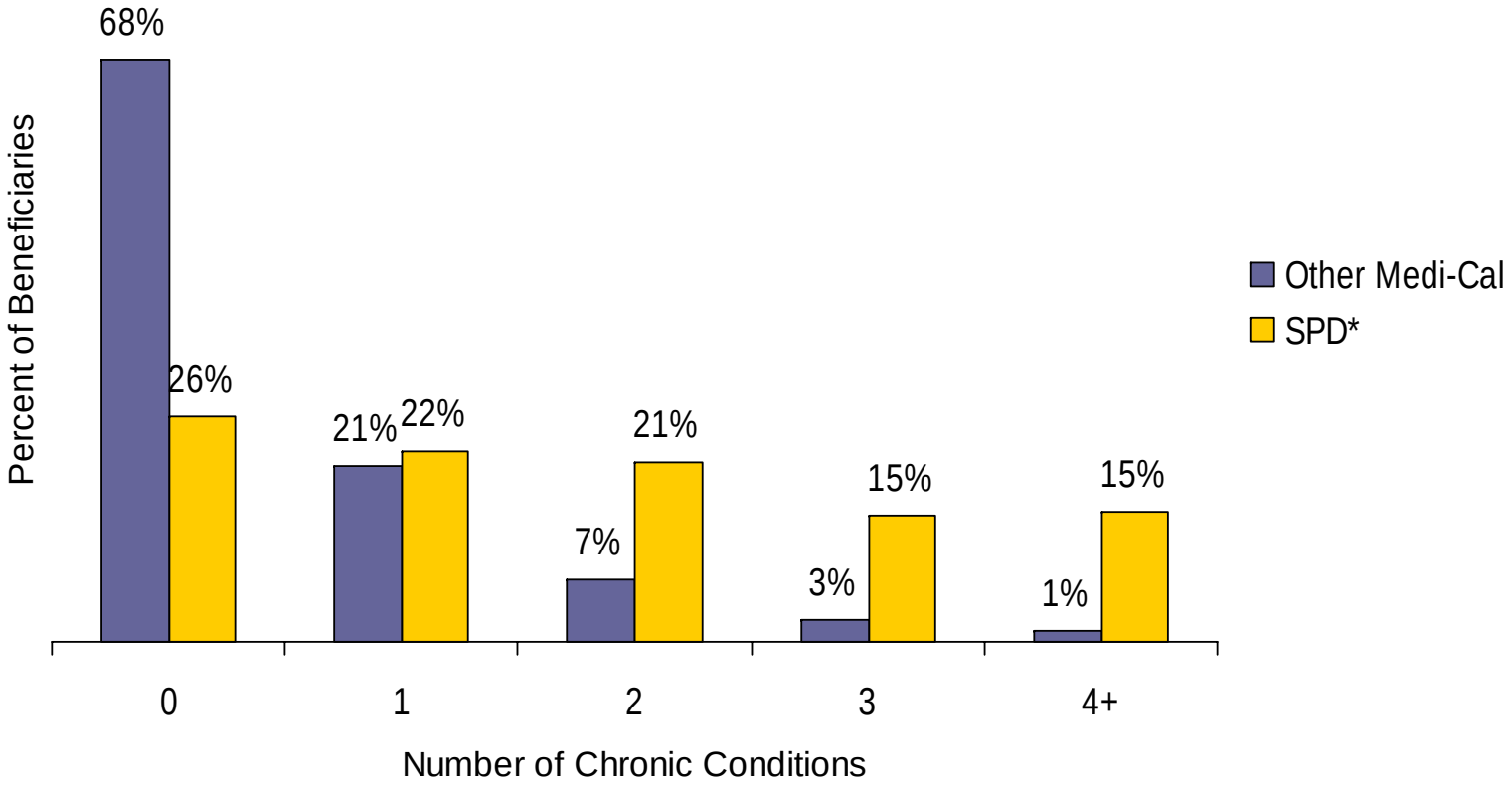
Seniors and people with disabilities account for 4 in 5 Medi-Cal beneficiaries in the top 5% cost group



Source: Public Policy Institute of California, Medi-Cal Expenditures: Historical Growth and Long-Term Forecasts (June 2005)

For SPDs, Coordination of Care is Essential, But Not Measured

Most seniors and people with disabilities have multiple chronic conditions and receive care from many different providers

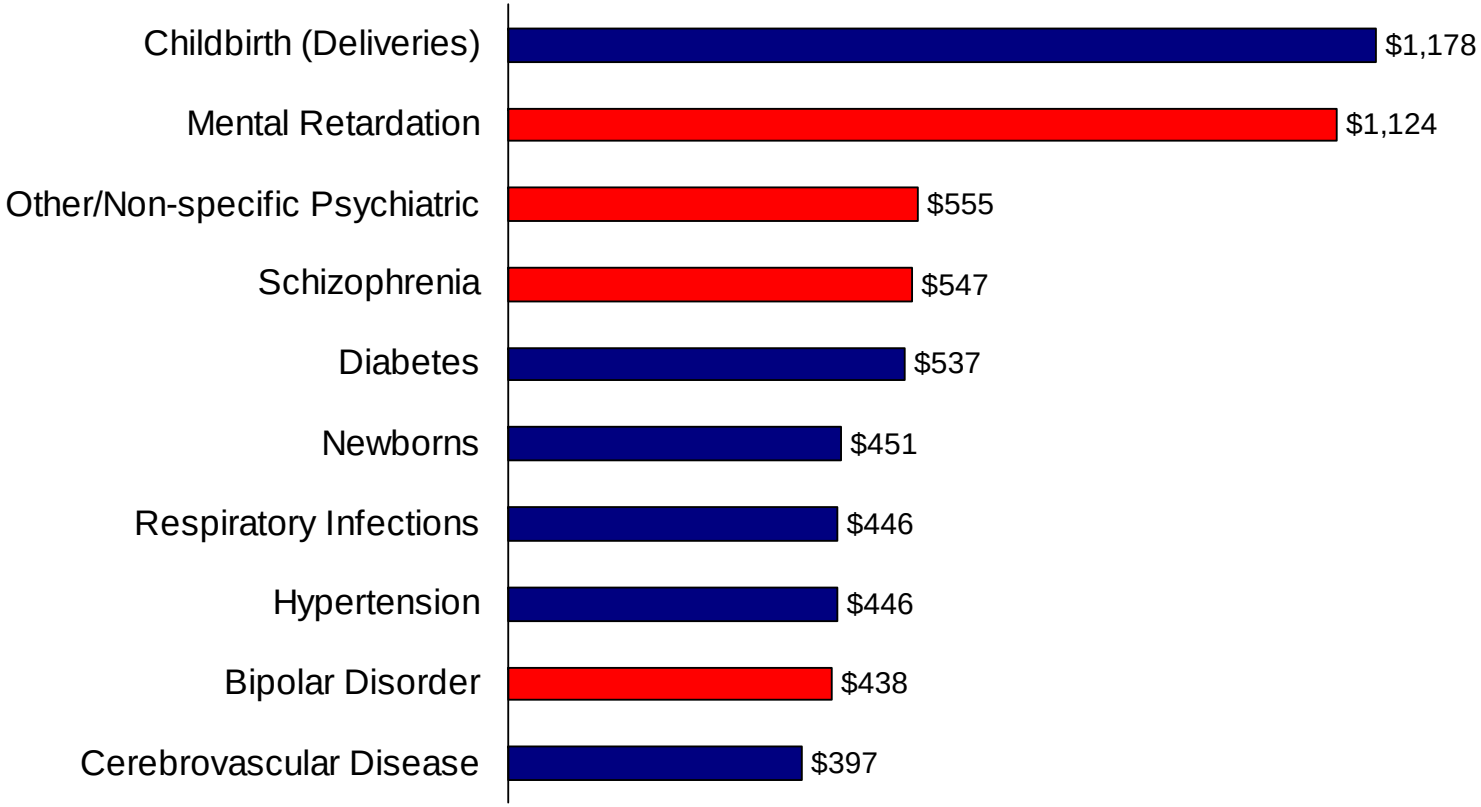


Source: The Lewin Group for CHCF. Analysis of 20% sample of Medi-Cal fee-for-service claims data, FY2001.
Note: Beneficiaries with Medicare coverage (dual-eligibles) are excluded.
* Among Medi-Cal-only SPD population, approximately 80% are under age 65.

Performance Measurement in Medi-Cal should include MR/DD and Mental Health

Medi-Cal spends more money treating mental retardation and mental illness than for most other conditions

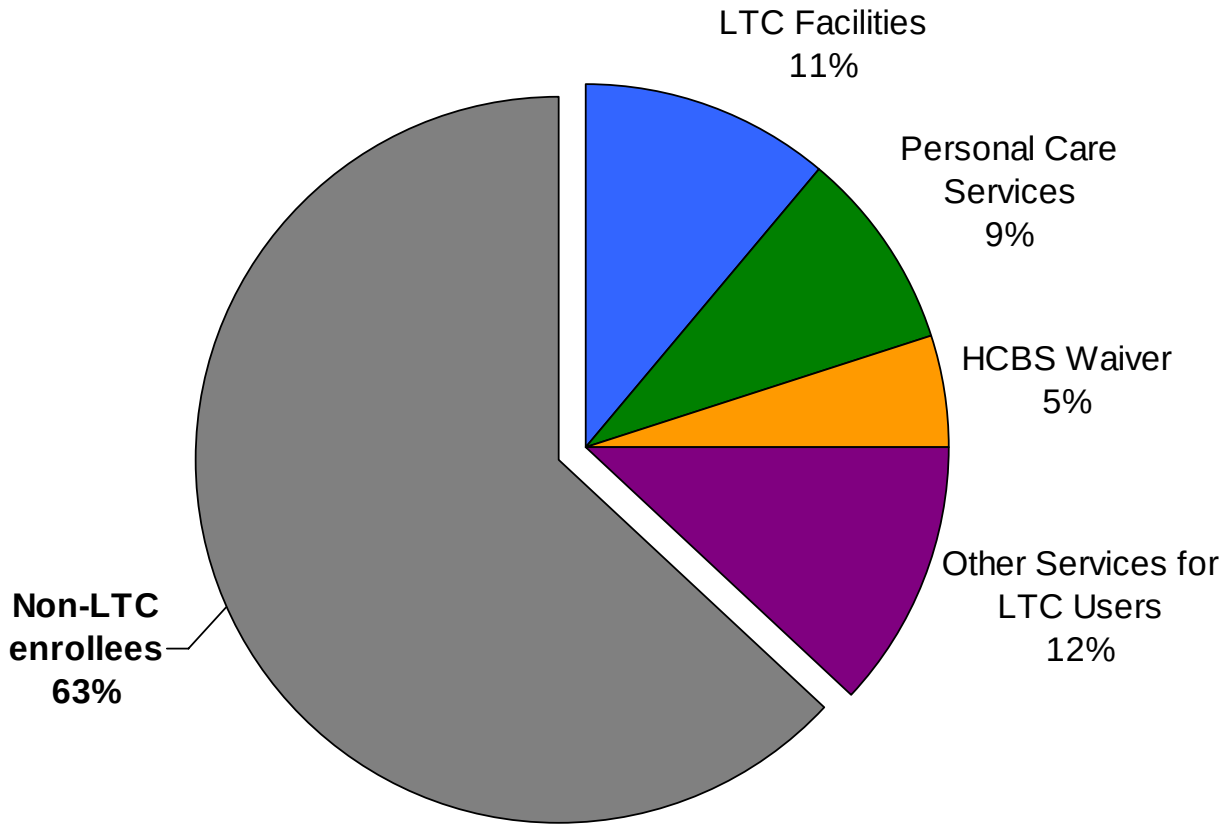
Fee-for-Service Payments (in $Millions) – Top 10 of over 200 episode of care categories



Source: CHCF, Medi-Cal Budget and Cost Drivers. Data from Medstat analysis of Medi-Cal MIS/DSS data updated through September 2005.

…and Long-Term Care!

LTC users account for 37% of Medi-Cal spending



Source: CHCF estimates. Reflects $28 billion of $34 billion in Medi-Cal spending (excludes DSH and other supplemental hospital payments, administrative expenses and certain other costs)

Performance-Based Auto-Assignment: A Good Start

- 200,000 beneficiaries, nearly 20% of new plan members, are “auto-assigned” each year
- New algorithm rewards plans which perform better than their competitor(s) and plans which improve performance over time
  - Quality (five HEDIS measures)
  - Safety net participation (one inpatient and one outpatient)
- In 2007, about 32,000 additional beneficiaries will be assigned to the highest performing plan in their county

The Next Step: P4P Collaboration

- Integrated Healthcare Association (California Plans)
- Bridges to Excellence
- CMS Physician Group Practice Demonstration
- CMS Premier Hospital Quality Incentive Demonstration